Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

Ship To: 1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DENTISTRY EXAMINING BOARD

PROCEDURE FOR REPORTING ADVERSE OCCURRENCES RELATED TO ANESTHESIA ADMINISTRATION

PER WISCONSIN ADMINISTRATIVE CODE:

DE 11.10: Reporting of adverse occurrences related to anesthesia administration. Dentists shall submit a report within 30-days to the Board of any mortality or other incident, which results in temporary or permanent physical or mental injury requiring hospitalization of a patient during, or as a result of, anesthesia administration under this chapter. The report shall be on a form approved by the Board and shall include, at the minimum, responses to all of the following:

1. A description of the dental procedures.
2. The names of all participants in the dental procedure and any witnesses to the adverse occurrence.
3. A description of the preoperative physical condition of the patient.
4. A list of drugs and dosage administered before and during the dental procedures.
5. A detailed description of the techniques utilized in the administration of all drugs used during the dental procedure
6. A description of the adverse occurrence, including the symptoms of any complications, any treatment given to the patient, and any patient response to the treatment.
7. A description of the patient's condition upon termination of any dental procedures undertaken.

Report the occurrence on the Report of Adverse Occurrences Related to Anesthesia Administration (**Form #2764**), obtainable from the Department of Safety and Professional Services at http://dsps.wi.gov.

Send (**Form #2764**) to the DSPS office at Wisconsin Dentistry Examining Board, DSPS, P.O. Box 8935, Madison, WI 53708-8935, and a copy should be kept for your records. You may fax to 608-261-7083 or email to dspscreddentistry@wisconsin.gov.

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DENTISTRY EXAMINING BOARD

REPORT OF ADVERSE OCCURRENCES RELATED TO ANESTHESIA ADMINISTRATION

PLEASE TYPE OR PRINT IN INK **(attach additional sheets if necessary)**

Name of Dentist:

Last Name | **First Name** | **MI** | **License Number** ____ - ____

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Date of Occurrence: __ __ / __ __ / __ __ __ __

Patient's Reaction:

Name(s)/Telephone Numbers of all participants in dental procedure and any witness to adverse occurrence:

Name — Daytime Telephone Number ___ - ___ - ____

Name — Daytime Telephone Number ___ - ___ - ____

Name — Daytime Telephone Number ___ - ___ - ____

Type of Dental Procedures performed: (provide detailed description)

Description of the preoperative physical condition of the patient:

Detailed description of techniques utilized in the administration of all drugs used during dental procedure:

Description of the adverse occurrence, including symptoms of any complications, treatment given to patient, and patient response to the treatment:

Description of patient's condition upon termination of any dental procedures undertaken:

Please provide all dental charting relevant to this occurrence.

Wisconsin Department of Safety and Professional Services

LIST OF DRUGS AND DOSAGES ADMINISTERED BEFORE AND DURING THE DENTAL PROCEDURES

Drugs Administered Before Dental Procedure(s):

	Name of Drug	Dosage Strength and Form	Quantity
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Drugs Administered During Procedure(s):

	Name of Drug	Dosage Strength and Form	Quantity
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

I certify that the foregoing information is correct to the best of my knowledge and belief.

Signature: _____ Date: __ __ / __ __ / __ __ __ __

Title: _____

#2764 (Rev. 12/16)
Ch. 447, Stats.